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MEDICAID

A BRIEF SUMMARY OF TITLE XIX OF
THE SOCIAL SECURITY ACT

1989

A BRIEF SUMMARY OF THE MEDICAID PROGRAM
(as of September 1, 1989)

Program Overview

Title XIX of the Social Security Act provides for a program of medical assistance for certain individuals and families with low incomes. The program, known as Medicaid, became law in 1965 as a jointly funded cooperative venture between the Federal and State governments. In 1988, the national Medicaid program provided services to 22.9 million eligible poor persons who were in certain families with dependent children, or were aged, disabled, or blind. The combined Federal and State outlay for the Medicaid program for 1988 was 51.6 billion dollars ($29 billion Federal and $22.6 billion State monies).

The Federal Medical Assistance Percentage (FMAP) portion of Medicaid expenses, to be paid by the Federal government, is determined annually for each State by a formula that compares a State's average per-capita income level with the National average. In 1988, this percentage varied from a prescribed minimum of 50% to 79.6%, (the weighted average was 56%), with the wealthier States receiving the lower FMAP matching rates.

Within broad Federal guidelines, each State: (1) determines its own eligibility requirements; (2) determines the amount, duration, and scope of services; (3) determines the rate of reimbursement for services; and (4) administers its own program. Thus, the Medicaid programs vary considerably from State to State, and over time.

Medicaid Eligibility

States have broad discretion in determining, within Federal guidelines and with FMAP support, which groups their Medicaid programs will cover and their financial criteria for Medicaid eligibility. States are required, however, to provide Medicaid coverage for most recipients who receive Federal and/or State income-maintenance assistance payments, as well as related groups not receiving cash payments.

These "mandatory" Medicaid groups include:

- recipients of aid to families with dependent children (AFDC), and those who lose AFDC due to earnings from work;

- recipients of adoption assistance and foster care under Title IV-E of the Social Security Act;
- children aged 1 through 6 and pregnant women who meet the State's AFDC financial requirements;
- Supplemental Security Income (SSI) recipients, (or aged, blind and disabled individuals in States that apply more restrictive eligibility requirements);
- certain other specifically-defined groups (protected coverage for limited periods for these special groups).
- certain Medicare beneficiaries (described later); and
- infants to age one and pregnant women whose family income is at or below 75% (beginning July 1, 1990, at or below 100%) of the Federal poverty level.

States also have the option to provide Medicaid coverage for other "categorically needy" groups. These optional groups share characteristics of the mandatory groups, but the eligibility criteria are somewhat more liberally defined. The broadest optional groups that States may cover (and receive Federal matching funds for) under the Medicaid program include:

- infants up to age 1 and pregnant women not covered under the mandatory rules whose family income is at or below 185% of the Federal poverty level (the percentage to be set by each State);
- certain children aged 1 through 7, plus aged, blind or disabled adults who have incomes or assets above those requiring mandatory coverage, but below the Federal poverty level;
- children under age 21 who meet the income and resources requirements for AFDC, but who otherwise are not eligible for AFDC;
- recipients of State supplementary payments;
- institutionalized individuals with income and resources below specified limits;
- persons receiving care under home and community-based waivers; and
- "medically needy" persons (described below).

The option to have a "medically needy" program allows States to provide Medicaid eligibility to certain additional individuals and families: those with high medical costs, who meet the eligibility requirements except that they have more income and/or countable resources than is allowed under the mandatory or optional categorically needy groups. Within this option, such persons may "spend down" to Medicaid eligibility by incurring medical and/or remedial care expenses that reduce their excess finances.

If a State elects to have a medically needy program, it is required to provide coverage to certain children under age 18 and pregnant women. It may also choose to include others: aged, blind, and disabled persons; caretaker relatives of children deprived of parental support and care; and certain other financially eligible children up to age 21. Thirty-six States provided Medicaid to at least some groups under a medically needy program in 1988.

Once entitlement to Medicaid is determined, coverage generally is retroactive to the third month prior to application. Coverage generally stops at the end of the month in which a person's circumstances change.

Medicaid does not provide medical assistance to all poor persons. To be eligible for Medicaid, a person must belong to one of the groups designated above. Even under the broadest provisions of the Federal statute (except for emergency services for a few specific persons), the Medicaid program does not provide health care services, even for very poor persons, unless they are in certain families with children who are deprived of parental support (AFDC), pregnant, under age 21, aged, blind, or disabled. Low income is only one test of eligibility; assets and resources are also tested.

Some States also have additional "State-only" programs to provide medical assistance for specified poor persons who do not qualify for the Medicaid program. No matching Federal funds are provided for State-only programs.

Scope of Medicaid Services

Title XIX of the Social Security Act requires that, in order to receive Federal matching funds, certain basic services must be offered in any State Medicaid program:

- inpatient hospital services;
- outpatient hospital services;
- laboratory and x-ray services;
- skilled-nursing facility (SNF) services for individuals aged 21 or older;

- home health care for persons eligible for skilled-nursing services;
- physician services;
- family planning services and supplies (at 90% FMAP for all States);
- rural health clinic services;
- nurse-midwife services;
- prenatal care; and
- early and periodic screening, diagnosis, and treatment (EPSDT) services for individuals under age 21.

In addition, States may elect to provide other optional services (currently 32 options) at the assigned FMAP rates. The most commonly covered optional services include:

- clinic services;
- intermediate-care facility (ICF) services for the aged and disabled;
- ICF services for the mentally retarded (ICFs/MR);
- optometrist services and eyeglasses;
- prescribed drugs;
- prosthetic devices;
- dental services; and
- SNF services for children under age 21.

Amount and Duration of Medicaid Services

Within broad Federal guidelines, States determine the duration and amount of services offered under their Medicaid programs. They may limit, for example, the days of hospital care or the number of physician visits covered. With certain exceptions, a State's Medicaid plan must allow recipients their freedom of choice among participating providers of health care. States may provide and pay for Medicaid services through various prepayment arrangements, such as health maintenance organizations (HMOs). As Federal regulations and options evolve and other factors impact their plans, States may alter their Medicaid services provisions.

States may also request administrative "waivers" under which they offer an alternative health care package for persons who would otherwise be institutionalized under Medicaid. States are not limited in the scope of services they can provide under such waivers, so long as they are cost effective (except that, other than as a part of respite care, they may not provide room and board for such "waivered" recipients).

Reimbursement for Medicaid Services

Medicaid operates as a vendor payment program. Reimbursements are made directly to the providers of services for care rendered to eligible individuals. Providers must accept the Medicaid reimbursement level as payment in full. States have broad discretion in determining the reimbursement methodology and resulting rate for services, subject to Federal upper limits, with two exceptions: (1) for institutional services, payments may not exceed Medicare reasonable-cost payment rates; and (2) for hospice care services, they must pay Medicare rates.

Reimbursement rates, however, must be reasonable and adequate to assure that services are available for the Medicaid population and to maintain the quality and supply of providers. Also, States must augment payments to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid recipients and/or other low-income persons.

States may impose nominal deductibles, coinsurance or co-payments on some Medicaid recipients for certain services. Emergency services and family planning services must be exempt from such co-payments. Certain Medicaid recipients must be excluded from this cost sharing: pregnant women, children under age 18, hospital or nursing home patients who are expected to contribute most of their income to institutional care, and categorically needy HMO enrollees.

Medicaid - Medicare Relationship

Some aged, blind and/or disabled poor persons are covered under both Medicaid and Medicare (Title XVIII of the Social Security Act). These recipients are known as "dual beneficiaries" or "dual eligibles." The Medicare program provides hospital insurance (HI - also known as "Part A") and supplementary medical insurance (SMI - also known as "Part B"). For those persons who are aged (65 or older), blind or disabled and who have insured status under Social Security, coverage for Part A is automatic.

Coverage for Part B, however, requires payment of a monthly premium. State Medicaid programs pay the premiums, deductibles and co-insurance for dual-eligible persons. Medicaid supplements Medicare coverage, and provides many health care services for the dual-eligible recipients that are not provided under Medicare. Such services as eye-glasses, hearing aids, SNF services beyond the 150 day limit provided by Medicare are included, as each State elects.

The Medicare Catastrophic Coverage Act of 1988 (MCCA) requires that State Medicaid programs also pay (on a phased-in basis) for the Medicare premiums, deductibles, and co-insurance for certain aged, blind, and disabled "qualified Medicare beneficiaries": those with incomes at or below 85% (phased in to 100% by 1992) of the Federal poverty level and resources at or below twice the standard allowed under the SSI program. This provides help for Medicare recipients who are not quite poor enough to qualify for Medicaid. These new MCCA beneficiaries are not eligible for full Medicaid benefits because of the new law; they benefit because their Medicare cost-sharing expenses are covered by Medicaid. In addition, the MCCA accelerates Medicaid eligibility for some nursing home patients by protecting more income and assets for the institutionalized persons' spouses living at home.

Medicaid Statistical Trends

Total Federal outlays for medical vendor payments under Medicaid have increased from $2.5 billion in fiscal year (FY) 1970 to $29 billion in FY 1988. Under current law, projected growth of Federal Medicaid expenditures between FY 1986 and FY 1993 is expected to average a compound rate of about 9% per year (or a doubling in 8 years). For 1994, the total Federal and State monies required as payments for the Medicaid program are projected to be approximately $88 billion, if current trends continue.

Medicaid recipients numbered 22,906,663 persons in 1988. Of these:

- 10,037,347 were dependent children under age 21,
- 5,503,317 were adults in families with dependent children,
- 3,158,818 were aged 65 or older,
- 3,401,136 were permanently and totally disabled,
- 85,838 were blind, and
- 1,343,460 were others within special groups of persons.

The most pronounced trend over the years has been the continued sharp increase in expenditures for nursing home care for the mentally retarded, disabled, and aged recipients. In FY 1988, the average Medicaid payment per person in a nursing facility for the mentally retarded was over $41,500, while the payment for an average AFDC child's total health services was about $584. The average 1988 Medicaid payment for nursing facility care for those aged 65+ was about $9,800 per recipient. In an average month in 1987, there were about 600,000 persons aged 65+ whose nursing home care was paid for primarily by Medicaid. Our Nation spent about $40.6 billion for all nursing home care in 1987, with 44% being paid for by Medicaid (including 58% of those 90,000 nursing home patients aged 95+).

Conclusion

Expenditures in the Medicaid program over the years have far exceeded the increase in numbers of persons or services provided. That is, the cost per Medicaid recipient has increased annually. This is due, primarily, to:

- the results of technological advances to keep very premature babies and other critically ill or severely injured persons alive, but in need of continuing expensive care;
- the increase in rates of reimbursement to the providers of health care;
- the increase in the numbers of very old persons and their required health care services; and
- the accelerated rate of inflation for medical and health related services compared to general inflation.

Initiatives related to Federal changes in the Medicaid program may come from either the President or Congress. There is no set limit (cap) on the amount of total Federal outlays for Medicaid. Rather, the Federal government must match whatever the individual State decides to provide, within the law, for its eligible citizens.

Responsibility for Federal over-sight of the Medicaid program lies with the Health Care Financing Administration (HCFA) in the Department of Health and Human Services (DHHS). DHHS, HCFA and the State Medicaid programs continually seek improvements in the quality and extent of health care services provided to our Nation's poor. Yet, they must function within the constraints of Federal and State budgetary limitations, as well as various other economic, social, and political factors that affect national and State decisions. Thus, with frequent revisions in Federal laws, in HCFA regulations, and in the individual State plans, the Medicaid program is continually changing.

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For a more thorough (500+ pages) explanation of Medicaid, see: Medicaid Source Book: Background Data and Analysis, from The Congressional Research Service in Washington, D.C.

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